DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 03 - 06

2. STATE: Virginia

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 430 to end of Title 42

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 $ (1,014,785)
b. FFY _____ $ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1 C, pp. 7-8, 16, 16-1
Attachment 4.19-D, pp. 54, 58

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT: Discontinue adult specialized care services reimbursement

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Secretary Health & Human Resources

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Patrick W. Finnerty

14. TITLE:
Director, DMAS

15. DATE SUBMITTED:
August 6, 2003

16. RETURN TO:
Dept. of Medical Assistance Services
600 East Broad Street, #1300
Richmond, VA 23219

ATTN: Reg Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
AUG - 8 2003

18. DATE APPROVED:
JAN 29 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL - 1 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
William Lasowski

22. TITLE:
Acting Deputy Director, CMSO

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

STANDARDS ESTABLISHED AND METHODS USED TO ASSURE HIGH QUALITY OF CARE

In order for reimbursement to be made to the nursing facility for a recipient requiring specialized care, the recipient must meet specialized care criteria as described in 12VAC30-60-320 (Adult Ventilation/Tracheostomy Specialized Care Criteria) or 12VAC30-60-340 (Pediatric/Adolescent Specialized Care Criteria). In addition, reimbursement to nursing facilities for residents requiring specialized care will only be made on a contractual basis. Further specialized care services requirements are set forth below.

In each case for which payment for nursing facility or specialized care services is made under the State Plan, a physician must recommend at the time of admission or, if later, the time at which the individual applies for medical assistance under the State Plan, that the individual requires nursing facility care.

F. For nursing facilities, a physician must approve a recommendation that an individual be admitted to a facility. The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. At the option of the physician, required visits after the initial visit may alternate between personal visits by the physician and visits by a physician assistant or nurse practitioner.

G. When the resident no longer meets nursing facility criteria or requires services that the nursing facility is unable to provide, then the resident must be discharged.

H. Specialized care services:

1. Providers must be nursing facilities certified by the Division of Licensure and Certification, State Department of Health, and must have a current signed participation agreement with the DMAS to provide nursing facility care. Providers must agree to provide care to at least four residents who meet the specialized care criteria for children/adolescents or adults.

2. Providers must be able to provide the following specialized services to Medicaid specialized care recipienst:

   a. Physician visits at least once weekly (after initial physician visit, subsequent visits may alternate between physician and physician assistant or nurse practitioner);

   b. Skilled nursing services by a registered nurse available 24 hours a day;

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STANDARDS ESTABLISHED AND METHODS USED TO ASSURE HIGH QUALITY OF CARE

c. Coordinated multidisciplinary team approach to meet the needs of the resident;

d. Infection control;

e. For residents under age 21 who require two of three rehabilitative services (physical therapy, occupational therapy, or speech-language pathology services), therapy services must be provided at a minimum of 90 minutes each day, five days per week;

f. Ancillary services related to a plan of care;

g. Respiratory therapy services by a board-certified therapist (for ventilator patients, these services must be available 24 hours per day);

h. Psychology services by a licensed clinical psychologist, a licensed clinical social worker, licensed professional counselor or licensed clinical nurse specialist-psychiatric related to a plan of care;

i. Necessary durable medical equipment and supplies as required by the plan of care;

j. Nutritional elements as required by the plan of care;

k. A plan to assure that specialized care residents have the same opportunity to participate in integrated nursing facility activities as other residents;

l. Nonemergency transportation;

m. Discharge planning; and

n. Family or caregiver training.

3. Providers must coordinate with appropriate state and local agencies for educational and habilitative needs for Medicaid specialized care recipients who are under the age of 21.

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PART II

12 VAC 30-60-320. Adult ventilation/tracheostomy specialized care criteria.

A. GENERAL DESCRIPTION: The resident must have long-term health conditions requiring close medical supervision, 24 hour licensed nursing care, AND specialized services or equipment.

B. The targeted adult population requiring specialized care includes individuals requiring mechanical ventilation and individuals with a complex tracheostomy who require comprehensive respiratory therapy services.

C. CRITERIA: The individual must require at a minimum:

1. Physician visits at least once weekly. The initial physician visit must be made by the physician personally and subsequent required physician visits after the initial visit may alternate between personal visits by the physician and visits by a physician assistant or nurse practitioner.

2. Skilled nursing services 24 hours a day. A registered nurse must be on the nursing unit on which the resident resides, 24 hours a day, whose sole responsibility is the designated unit.

3. Respiratory services provided by a licensed board-certified respiratory therapist (these services must be available 24 hours a day); and

4. A coordinated multidisciplinary team approach to meet needs.

D. In addition, the individual must meet one of the following two requirements:

1. Require a mechanical ventilator; or

2. Have a complex tracheostomy that meets **all** of the following criteria. The individual must:

   a. Have a tracheostomy, with the potential for weaning off of it, OR documentation of attempts to wean, with subsequent inability to wean;

   b. Require nebulizer treatments followed by chest PT (physiotherapy) at least four times per day, OR nebulizer treatments at least four times a day, which must be provided by a licensed nurse or licensed respiratory therapist;

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c. Require pulse oximetery monitoring at least every shift due to demonstrated unstable oxygen saturation levels;

d. Require respiratory assessment and documentation every shift by licensed respiratory therapist or trained nurse;

e. Have a physician's order for oxygen therapy with documented usage and for;

f. Require tracheostomy care at least daily;

g. Have a physician's order for suctioning as needed; AND

h. Be deemed to be at risk of requiring subsequent mechanical ventilation.

Ed. Note: This page replaces pages 16.1 through 16.3. The next page is 17.

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C. The director's determination shall be deemed to be final on (i) the due date of any cost report filed by the provider indicating that an overpayment has occurred, or (ii) the issue date of any notice of overpayment, issued by DMAS, if the provider does not file an appeal, or (iii) the issue date of any administrative decision issued by DMAS after an informal fact finding conference, if the provider does not file an appeal, or (iv) the issue date of any administrative decision signed by the director, regardless of whether a judicial appeal follows. In any event, interest shall be waived if the overpayment is completely liquidated within 30 days of the date of the final determination. In cases in which a determination of overpayment has been judicially reversed, the provider shall be reimbursed that portion of the payment to which it is entitled, plus any applicable interest that the provider paid to DMAS.

12VAC30-90-255 to 12VAC30-90-259. Reserved.

Subpart XVI
Revaluation of Assets

12VAC30-90-260. Repealed.

12 VAC 30-90-261 through 12 VAC 30-90-263. Reserved.

12VAC30-90-264. Specialized care services.

Specialized care services provided in conformance with 12VAC30-60-40 E and H, 12VAC30-60-320 and 12VAC30-60-340 shall be reimbursed under the following methodology. The nursing facilities that provide adult specialized care for the category of Ventilator Dependent Care will be placed in one group for rate determination. The nursing facilities that provide pediatric specialized care in a dedicated pediatric unit of eight beds or more will be placed in a second group for rate determination.

1. Routine operating cost. Routine operating cost shall be defined as in 12VAC30-90-271 and 12VAC30-90-272. To calculate the routine operating cost reimbursement rate, routine operating cost shall be converted to a per diem amount by dividing it by actual patient days.

2. Allowable cost identification and cost reimbursement limitations. The provisions of Article 5 (12VAC30-90-50 et seq.) of Part II of this chapter and of Appendix III (12VAC30-90-290) of Part III of this chapter shall apply to specialized care cost and reimbursement.

3. Routine operating cost rates. Each facility shall be reimbursed a prospective rate for routine operating costs. This rate will be the lesser of the facility-specific prospective routine operating ceiling, or the facility-specific prospective routine

b. Kinetic therapy devices will have a limit per day (based on 1994 audited cost report data inflated to the rate period). See 12VAC30-90-290 for the cost reimbursement limitations.

c. Kinetic therapy devices will be reimbursed only if a resident is being treated for wounds that meet the following wound care criteria. Residents receiving this wound care must require kinetic bed therapy (that is, low air loss mattresses, fluidized beds, and/or rotating/turning beds) and require treatment for a grade (stage) IV decubitus, a large surgical wound that cannot be closed, or second to third degree burns covering more than 10% of the body.

9. Covered ancillary services are defined as follows: laboratory, X-ray, medical supplies (e.g., infusion pumps, incontinence supplies), physical therapy, occupational therapy, speech therapy, inhalation therapy, IV therapy, enteral feedings, and kinetic therapy. The following are not specialized care ancillary services and are excluded from specialized care reimbursement: physician services, psychologist services, total parenteral nutrition (TPN), and drugs. These services must be separately billed to DMAS. An interim rate for the covered ancillary services will be determined (using data from the most recent settled cost report) by dividing allowable ancillary costs by the number of patient days for the same cost reporting period. The interim rate will be retroactively cost settled based on the specialized care nursing facility cost reporting period.

10. Capital costs. Effective July 1, 2000, capital cost reimbursement shall be in accordance with 12 VAC 30-90-35 through 12 VAC 30-90-37 inclusive of the NHPS, except that the 90% occupancy requirement shall not be separately applied to specialized care. Capital cost related to specialized care patients will be cost settled on the respective nursing facility's cost reporting period. In this cost settlement the 90% occupancy requirement shall be applied to all the nursing facility's licensed nursing facility beds inclusive of specialized care.